Group Disability Proof / Evidence of Insurability Application

This form is for residents of AL, AK, AZ, AR, CA, CO, CT, DE, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MS, MO, MT, NE, NV, NH, NM, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, & WY.

Instructions for Employee/Member:

1. It is required that you be given the "NOTICE TO PROPOSED INSURED REGARDING MEDICAL INFORMATION BUREAU & INFORMATION PRACTICES." Please read it carefully and keep it for your records.
2. Please complete Part 2 of the form. **Incomplete information will result in delays.** Type or print clearly with blue or black ink. We cannot accept faxed or photocopied applications, applications completed in pencil, or customized applications that have not been approved by the EOI Department. Enrollment forms are not considered EOI Applications.
3. If a question or item of information requested is not applicable, please write in "none" or "no."
4. **If you make any changes to the application, please initial and date next to the change(s).**
5. Keep this portion of the form, and be sure to keep a copy of the completed application. Send original completed application to:

Group Insurance Commission
Systems Unit
P.O. Box 8747
Boston, MA 02114-8747

NOTICE TO PROPOSED INSURED REGARDING MEDICAL INFORMATION BUREAU & INFORMATION PRACTICES

In order to properly underwrite and administer your application for insurance coverage, we must collect certain information concerning your insurability. You are our most important source of information, but we may also contact other sources, including medical professionals and institutions, employers and other insurance companies. In certain instances, we may also need to conduct an investigative consumer report. This usually takes the form of a personal interview that is conducted with you in person or over the telephone. If an interview is conducted with someone other than you, we will inform you of your right to be interviewed in connection with the preparation of the investigative consumer report. All information regarding your insurability will be treated as confidential.

You have the right to be told about, and to see (and copy if you wish), items of personal information about you which appear in our files, including the nature and scope of information contained in investigative consumer reports. You also have the right to seek correction, amendment or deletion of information you believe to be inaccurate.

The Company may also make information in its files available to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

The Company may make a brief report regarding your insurability to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Continental Casualty Company
(herein called the "Company")

GROUP DISABILITY PROOF/EVIDENCE OF INSURABILITY
Form B1-64448-L

Complete ALL information. Incomplete information will result in delays. Type or print clearly with blue or black ink. Forward the original application to the GIC.

I. Employer Information	LONG TERM DISABILITY	Policy Number: SR-83130411

Employer's Name Commonwealth of Massachusetts X Late Enrollee	**Employer's Mailing Address** Group Insurance Commission P.O. Box 8747 Boston, MA 02114

II. Employee Application For Coverage (TO BE COMPLETED BY EMPLOYEE)

1. Employee's Name	Gender	Date of Birth	State of Birth	Social Security #

Residential Street Address City State Zip Code	Home Phone	Height Ft. In.	Weight Lbs.

2. Occupation	Work Phone Number	Date of Full-Time or Half-Time Employment	Number of hours you are schedule to work in a regular workweek?	Annual Salary

Duties:	(b) Are you currently performing the duties of your occupation for a regular workweek? (If NO, explain in remarks section below) ☐YES ☐NO

3. (a) What other disability income insurance are you now carrying or have an application or reinstatement pending for? (If none, please indicate)

COMPANY	BENEFIT AMOUNT(S)	ELIMINATION PERIOD ACCIDENT/SICKNESS	MAXIMUM BENEFIT PERIOD ACCIDENT/SICKNESS

(b) Have you ever had any disability income insurance postponed, rated, waivered, declined, canceled or had reinstatement refused? If YES, give dates, company name and reason in the remarks section below. ☐YES ☐NO

Remarks: Questions 2b and 3b (if additional space is needed, use a signed, dated separate sheet.)

4. To the best of your knowledge and belief, have you within the last 10 years been medically treated or medically diagnosed for any of the following:

(a) Epilepsy, paralysis, or any nervous, mental or emotional disorder? ..... ☐YES ☐NO
(b) Abnormal blood pressure, heart attack, heart murmur, stroke; any other blood, heart, or circulatory disorder? ..... ☐YES ☐NO
(c) Any lung or respiratory disorder? ..... ☐YES ☐NO
(d) Ulcer of the stomach or duodenum; any rectal, liver or gall bladder disorder, or any other digestive disorder? ..... ☐YES ☐NO
(e) Kidney or any urinary disorder, albumin, pus or sugar in urine, disorder of the prostate or genital organs? ..... ☐YES ☐NO
(f) Thyroid disorder, diabetes, gout, any eye or ear disorder, any discolored areas or lesions of the skin or mouth? ..... ☐YES ☐NO
(g) Arthritis, rheumatism, any disorder of the back, spine, bones, muscles or joints? ..... ☐YES ☐NO
(h) Cancer, tumor, growth, enlarged lymph nodes or any skin disorder? ..... ☐YES ☐NO

(i) Alcoholism, drug dependency or substance abuse? ..... ☐YES ☐NO

(j) Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ..... ☐YES ☐NO

5. **When and why** did you last consult a doctor? _____

   (a) What were you told about the findings? _____

   (b) What Treatment and drugs were prescribed? _____

   (c) Are you still under treatment? _____ ☐YES ☐NO

6. To the best of your knowledge and belief, have you ever had any physical impairment, deformity, sickness, operations, injuries or check-ups during the past 5 years other than admitted in questions 5 or 6? ..... ☐YES ☐NO

7. To the best of your knowledge and belief, are you pregnant at this time? ..... ☐YES ☐NO

8. **If any answer to questions 5, 6 or 7 is YES, complete the following.** (If additional space is needed, use a signed, dated separate sheet.)

QUESTION #	MEDICAL CONDITION	DATES From – To	RESULTS	DOCTOR OR HOSPITAL NAMES & ADDRESSES
		–		
		–		
		–		

I UNDERSTAND and AGREE that the statements and answers in this application are complete and true to the best of my knowledge and belief. I also understand and agree that the insurance applied for, if issued, shall be subject to such statements and answers.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, consumer reporting agency, employer, or the Veterans Administration, having information available as to advice, diagnosis, treatment, or care of any physical or mental condition concerning me, including information about drugs, alcoholism, or mental illness, and any other non-medical information concerning me, to give to the CNA Group Life Assurance Company or Continental Assurance Company, its affiliates, its legal representative, or its reinsurers any and all such information.

I UNDERSTAND that information obtained by use of this Authorization will be used by the CNA Group Life Assurance Company or Continental Assurance Company or its affiliates to determine eligibility for insurance.

I UNDERSTAND that any expenses incurred as a result of a required medical examination will be borne by the applicant.

I KNOW that I may request to receive a copy of this Authorization. I AGREE that a copy of this Authorization shall be as valid as the original. I AGREE that this Authorization shall remain valid for two years from the date shown below.

I ACKNOWLEDGE having received and read the Notice Regarding Medical Information Bureau. I UNDERSTAND that this application will remain in effect for 90 days from the date shown below.

_____ _____

Date Signed Signature of Applicant